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Electronic Newsletter

Perinatal network

Maryland Department of Health and Mental Hygiene

The Perinatal Network News is a publication of the Department of Health and Mental Hygiene's (DHMH) Center for Maternal and Child Health (CMCH). It is funded through a Crenshaw Perinatal Health Initiative grant provided to the Montgomery County Health Department.

The publication is intended as a communication tool for sharing perinatal information for a statewide audience, with information and resources that address statewide issues. It is designed as a vehicle to encourage collaboration and networking throughout the state. The newsletter provides an opportunity to share information on preconception and perinatal health issues and priorities, infant morbidity and mortality, county statistical trends and perinatal and child health indicators. It is an opportunity for local programs to share their strengths and insights as well as opportunities to ask for feedback and assistance in solving a local problem.

To ensure that this newsletter is a success, we need and encourage your participation. Please let us know of any items you would like to contribute, or if you have suggestions for topics or areas you would like to see covered.

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Telemedicine in Obstetrics?

Jenifer O. Fahey, CNM, MSN, MPH. University of Maryland School of Medicine, Department of Obstetrics, Gynecology, And Reproductive Services

As part of its Perinatal Outreach Program, funded in part by the Department of Health and Mental Hygiene, the University of Maryland's Department of Obstetrics, Gynecology and Reproductive Medicine has launched a pilot project to explore the feasibility and desirability of incorporating telemedicine into the delivery of obstetric care in the State of Maryland. The Institutes of Medicine defines telemedicine as the use of electronic information and communications technologies to provide and support healthcare when distance separates the participants. Almost all medical practices in every field of medicine already use some form of telemedicine in the care of their patients - usually in the form of phone consultations. These consultations, most often involve two or more health care providers exchanging information regarding the care of a patient or patients. In the last decade, the ability to transmit images has evolved, and, as a result, we are now able to integrate the patient into these remote consultations and other remote patient care activities. In the field of obstetrics, providers are already making use of this technology. In Texas, for example, health care providers at academic institutions interpret ultrasound images of pregnant inmates. In California, another academic institution provides assistance in interpreting electronic fetal monitoring strips on a labor and delivery unit hundreds of miles away. In Hawaii, perinatologists based in Honolulu conduct remote video consultations with pregnant patients on the smaller islands.

Telemedicine provides us with an opportunity to use technology to extend the reach of our health care system. This capability is particularly important in a time of uneven distribution of health care resources and dwindling number of providers of obstetric care. Telemedicine also allows for cost containment and can put specialty services, such as those provided by perinatologists within reach of remote or isolated populations. Similarly, telemedicine allows community hospitals and community providers to connect remotely to lectures and presentations occurring in urban centers and academic and research institutions as well as to conduct case presentations and discussions.

Currently, many of the high-risk consultations that perinatologists conduct with women traveling from remote areas do not require a physical exam or labwork beyond that which can be done at their regular provider's office or local laboratory either prior to the consult or as a follow-up to the consult. What many of these women and their providers truly need from the perinatologists is assistance in creating and maintaining a plan of care. It is possible for many of these women to be managed locally with appropriate consultative support from perinatologists thus avoiding the cost and inconvenience to remote locations for visits in which a physical exam is not essential. In addition to serving as a cost

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containment measure and serving to reduce the inconvenience to the patient, telemedicine increases the viability of community practices by allowing access to expertise that enables them to continue to care for these women in their own communities.

The widespread adoption of these technologies have been limited by a variety of factors including issues surrounding reimbursement and legal questions such as licensure to conduct remote consultation. There are also inherent drawbacks to remote consultations that must be addressed. Critics of telemedicine argue that telemedicine is second best medicine that cannot replace face-to-face interactions with providers. Furthermore, telemedicine relies on functioning lines and equipment at each of the sites that are attempting to connect with each other. A malfunction on either end can mean that the consultation must be cancelled, thus decreasing the usefulness of remote consultation as a cost and time saving measure. Finally, through the long course of pregnancy and labor it is highly likely that women will still need to travel on occasion for things such as targeted sonograms or other diagnostics or treatments. The pilot project at the University of Maryland aims to determine if and how telemedicine might best be used in our state to extend the services and expertise available in our academic institutions in Baltimore to serve women and providers throughout the State of Maryland. Stay tuned, or shall we say, stay connected for updates on this project.

Update on the Medicaid Maryland Family Planning Program

Donna Devilbiss, RN, Maryland Medical Care Programs

Pregnant women who had the Maryland Children's Health Program (MCHP) to cover their prenatal care and delivery, automatically received the Maryland Family Planning Program card two months after their delivery. In the past, women were eligible for five years of continuous family planning coverage.

What are the changes?

As of July 1, 2005, a federal mandate requires the Department of Health and Mental Hygiene to begin a financial renewal process for women enrolled in the Maryland Family Planning Program. Women entering the Family Planning Program are now given two years of continuous coverage and then must complete a financial renewal process to continue their coverage. Approximately 10 weeks before the family planning eligibility period ends, the woman will receive a letter explaining the new process and a request for information worksheet to be completed and returned to the Department.

If the woman is still financially eligible, she will receive an approval letter and will continue coverage for another year. This process will be repeated annually until she reaches the end of her five-year eligibility period. If the woman is financially ineligible, she will receive a letter of denial and her family planning coverage will end.

How can I help with this new process?

You can assist women with this new process by encouraging them to call our toll-free line to update their name and address to ensure accurate information in our database. The toll-free telephone is 1-800-456-8900. You can also remind women of the importance of responding to the request for information and to sign and date their renewal worksheet.

Where can I call if I have questions?

Feel free to contact us at 800-456-8900 for questions or concerns.



Pregnant Women Living in Highly Polluted Areas More Likely To Deliver Low-Birthweight Infants

Pregnant women who live in areas with high levels of fine-particle air pollution are more likely to give birth to an infant of below-average weight. Dr. Jennifer Parker of the National Center for Health Statistics and colleagues studied the birth records of 18,247 full-term infants born in California in 2000 and found that a woman's exposure to fine-particle air pollution had an inverse relationship with her infant's birthweight. About 9.2 percent of infants born to women living in the areas with the highest levels of air pollution had below-average birthweights for their gestational age, while 8.5 percent of infants born to women living in the least-polluted areas had below-average birthweights, according to the study.

Overall, the average birthweight of infants born to women living in the most highly polluted areas was one ounce less than infants born in "clean-air cities." Below-average birthweights were most common among infants born to mothers exposed to fine particles of pollution measuring 18.4 micrograms per cubic meter of air. The Environmental Protection Agency standard is 15 micrograms per cubic meter of air, according to Tracey Woodruff, a scientist at EPA and co-author of the study.

Chan McDermott, prenatal coordinator for the Texas Department of State Health Services, said the findings are "most significant" for infants "already susceptible to low birthweight." John Balbus, health program director for the not-for-profit organization Environmental Defense, said, "This is one more piece of evidence that fine-particle pollution needs to be dealt with as soon as possible."

Pediatrics Vol. 115 No. 1 January 2005. Jennifer D. Parker, PhD, Tracey J. Woodruff, PhD, MPH, Rupa Basu, PhD and Kenneth C. Schoendorf, PhD, MPH

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New Hotline for Physicians Treating HIV+ Pregnant Women

A new perinatal hotline service (888-448-8765) is now providing clinicians with 24-hour consultation from HIV experts on treating HIV-infected pregnant women and their children as well as advice on indications and interpretations of HIV testing in pregnancy. The Perinatal Hotline (the National Perinatal HIV Consultation and Referral Service), was developed by the HIV/AIDS Bureau of the Health Services and Resources Administration (HRSA), and will be an expansion of HRSA's National HIV/AIDS Clinicians Consultation Center (NCCC) at San Francisco General Hospital.

"Our aim is to make sure clinicians nationwide, especially those who may not have much experience with HIV, can get readily available expert consultation. For clinicians caring for pregnant women, this will not only include consultation during prenatal visits, but also during the critical period in the labor and delivery room and postpartum," said the Hotlines Co-Assistant Director, Jessica Fogler, MD, Assistant Clinical Professor of Family and Community Medicine at UCSF.

In addition, the Perinatal Hotline will provide vital advice on implementing the U.S. Public Health Service clinical care guidelines. These guidelines recommend testing pregnant women for HIV as early as possible in prenatal care. HIV testing during pregnancy and HIV treatment for HIV-infected pregnant women and their newborns has resulted in a dramatic reduction of mother to-child HIV transmission. "As access to rapid HIV testing becomes more available, clinicians who treat pregnant women will have an increased need for 24-hour consultation in interpreting HIV tests and applying the Public Health Service guidelines to prevent HIV transmission to newborns," said the Hotlines Co-Assistant Director, Deborah Cohan, MD, MPH, Assistant Clinical Professor of Obstetrics, Gynecology and Reproductive Sciences at UCSF.

The Perinatal Hotline will not only be available around the clock to answer callers' immediate questions and help solve urgent perinatal HIV issues, but will also assist clinicians in linking HIV-infected women and HIV-exposed infants to the most appropriate care. Callers will be referred to a national network of education, training and consultation services available from HRSA's regional AIDS Education and Training Centers and to clinicians with expertise in caring for perinatal HIV.

The NCCC also offers two other free national telephone advice services for clinicians. The National HIV Telephone Consultation Service (Warmline) at 800-933-3414 provides advice on treating HIV. The Warmline is available to clinicians from 8 a.m. to 8 p.m. EST, Monday through Friday. The National Clinicians' Post-Exposure Prophylaxis Hotline (PEpline) at 888-448-4911 provides 24-hour consultation regarding health care worker exposures to bloodborne pathogens, HIV and hepatitis. "We have provided more than 75,000 confidential telephone consultations over the last decade answering clinicians HIV treatment questions and managing exposures to blood-borne pathogens to health care workers," said NCCC director, Ronald Goldschmidt, MD, Director of the Family Practice Inpatient Service at San Francisco General and UCSF Professor of Family and Community Medicine.

The NCCC is part of the AIDS Education and Training Centers Program funded by the Ryan White CARE Act through HRSA's HIV/AIDS Bureau in partnership with the Centers for Disease Control and Prevention and the HRSA Division of Community Based Programs.

For more information call: Ronald Goldschmidt, MD 415-206-5792
rgoldschmidt@nccc.ucsf.edu

Web site: www.ucsf.edu/hivcntr

HIV Prevention Resources

The Health Research and Educational Trust (HRET), with support from the Centers for Disease Control and Prevention (CDC), has developed a summary chart of FDA-Approved Rapid HIV Antibody Screening Tests. Many hospitals are currently considering how best to meet the CDC recommendation for hospitals to offer routine rapid HIV testing to all women presenting to labor and delivery with undocumented HIV status.

HRET, with input from the CDC, has developed a chart to present hospitals with the information they need to decide which rapid HIV test to use in their practices. The chart summarizes and compares the rapid HIV tests currently FDA-approved and available for commercial distribution, including the newly approved MultiSpot HIV-1/HIV-2 Rapid Test. Visit the HRET's Web site: www.hret.org



The Centers for Disease Control and Prevention (CDC) has developed an HIV prevention initiative—Advancing HIV Prevention: New Strategies for a Changing Epidemic—aimed at reducing barriers to early diagnosis of HIV infection and, if positive, increasing access to quality medical care, treatment and ongoing prevention services.

One of the four key strategies is: Further decrease perinatal HIV transmission. CDC will promote recommendations and guidance for routine HIV testing of all pregnant women, and, as a safety net, for the routine screening of any infant whose mother was not screened. CDC will work with prevention partners, including the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Nurse-Midwives, to disseminate the recommendations and support their implementation.

For information resources from the CDC HIV Prevention Division:
www.cdc.gov/hiv/dhap.htm

FDA-Approved Rapid HIV Antibody Screening Tests

January 10, 2005

	FDA Approval Received	Specimen Type	CLIA Category*	Sensitivity** (95% CI)	Specificity** (95% CI)	Manufacturer	Approved for HIV-2 Detection?	List Price Per Device^	External Controls
OraQuick Rapid HIV-1 Antibody Test	Nov 2002	Whole blood (fingerstick or venipuncture)	Waived	99.6% (98.5-99.9)	100% (99.7-100)	OraSure Technologies, Inc. www.orasure.com	No	\$14.50	Sold Separately (\$20 each)
OraQuick ADVANCE Rapid HIV-1/2 Antibody Test	Mar 2004	Oral fluid	Waived	99.3% (98.4-99.7)	99.8% (99.6-99.9)	OraSure Technologies, Inc. www.orasure.com	Yes	\$17.50	Sold Separately (\$25 each)
		Whole Blood (finger stick or venipuncture)	Waived	99.6% (98.5-99.9)	100% (99.7-100)				
		Plasma	Moderate Complexity	99.6% (98.9-99.8)	99.9% (99.6-99.9)				
Uni-Gold Recombigen HIV	Dec 2003	Whole blood (fingerstick or venipuncture)	Waived	100% (99.5-100)	99.7% (99.0-100)	Trinity Biotech www.unigoldhiv.com	No	\$15.75	Sold Separately (\$26.25 each)
		Serum & Plasma	Moderate Complexity	100% (99.5-100)	99.8% (99.3-100)				
Reveal G-2 Rapid HIV-1 Antibody Test	Apr 2003	Serum	Moderate Complexity	99.8% (99.5-100)	99.1% (98.8-99.4)	MedMira, Inc. www.medmira.com	No	\$14.00	Included
		Plasma	Moderate Complexity	99.8% (99.5-100)	98.6% (98.4-98.8)				
MultiSpot HIV-1/HIV-2 Rapid Test	Nov 2004	Serum	Moderate Complexity	100% (99.94-100)	99.93% (99.79-100)	BioRad Laboratories www.biorad.com	Yes - differentiates HIV-1 from HIV-2	\$25.00	Included
		Plasma	Moderate Complexity	100% (99.94-100)	99.91% (99.77-100)				

* Clinical Laboratory Improvement Amendments: CLIA regulations identify three categories of tests: waived, moderate complexity, or high complexity.
 ** Sensitivity is the probability that the test result will be reactive if the specimen is a true positive; specificity if the probability that the test result will be nonreactive if the specimen is a true negative. Data are from the FDA summary basis of approval, for HIV-1 only. For HIV-2 infomtion, see package inserts.
 ^ Actual price may vary by purchasing agreements with manufacturers.

Note: Trade names are for identification purposes only and do not imply endorsement.



Childhood Lead Poisoning

Cindy Edwards, Nurse Administrator, Childhood Lead Poisoning Prevention Program Montgomery County HHS

There are many sources of lead poisoning in young children. Common sources include lead-based paint that is flaking and/or peeling or has been scraped into a fine invisible dust, older plumbing fixtures, painted toys, parent's work-exposure, hobbies using lead products, folk remedies and foods made in non-regulated countries of the world, jewelry and medallions, or working in or living near car repair shops or working with leaded money clips in financial institutions. In addition lead sediment can be found in soil where renovations have taken place and in older homes undergoing renovation.

Pregnant women with lead in their bodies can pass it to their fetus through blood circulation. Lead can cause premature birth, low birth weight, miscarriage or still birth, and learning and behavior problems in the baby. In an unborn fetus, lead circulates in the blood from the mother and settles in the brain and nervous system, bones, and kidneys where damage starts early. Blood lead testing during pregnancy will allow for early intervention and hopefully decrease the effects of lead poisoning on the baby. Medical monitoring, exercise, and a diet including the five basic food groups, calcium, iron and folic acid are essential to lessen the effects of lead.

Lead poisoning is of greatest concern for infants and children under the age of six because they absorb lead more readily. The symptoms of lead poisoning are very subtle and lead is highly toxic. A blood test is the only way to check for blood lead poisoning. The blood lead test is recommended to be done at age one and two for any child who lives in or spends time in older buildings or in areas where there is reconstruction being done.

A blood lead level of 10mcg/dl is a concern. An elevation of 10mcg/dl leads to nervous system damage which can lower a child's IQ level, cause behavioral problems and learning disabilities, impair growth and cause hearing loss and anemia. Case management by Montgomery County's Childhood Lead Poisoning Prevention Program starts at a level of 15mcg/dl. A child with a blood lead level of 20mcg/dl and higher is considered to be poisoned. Aggressive behavior, irritability, weight loss, poor attention span and muscle weakness are some symptoms that can occur with lead poisoning and elevated blood lead levels over a period of time. Seizures and death can occur at levels of 90-100. Treatment with medications is done with very high blood lead levels.

There are some preventive measures that can help. A healthy diet high in vitamin C, high in calcium and high in iron should be encouraged. Fried foods and fast foods should be discouraged. Frequent hand washing is very important especially before meals. Damp dusting and mopping is a good way to eliminate lead dust during home remodeling. Wash toys frequently and encourage playing in grassy areas.



CDC Childhood Lead Poisoning Prevention Program

The Centers for Disease Control Web site has resources on the topic and an article entitled Preventing Lead Exposure in Young children: A Housing-Based Approach to Primary Prevention of Lead Poisoning containing recommendations from the advisory committee on childhood lead poisoning prevention. Visit: www.cdc.gov/nceh/lead/lead.htm

Warning About Lead in Candy from Mexico

The FDA advises that parents, care providers, and others not allow children or pregnant women to eat candy imported from Mexico at this time. The potential for children to be exposed to lead from candy imported from Mexico has prompted the U.S. Food and Drug Administration (FDA) to issue warnings on the availability of lead-contaminated candy and to develop tighter guidelines for manufacturers, importers, and distributors of imported candy.

Lead has been found in some consumer candies imported from Mexico. Certain candy ingredients such as chili powder and tamarind may be a source of lead exposure. Lead sometimes gets into the candy when processes such as drying, storing, and grinding the ingredients are done improperly. Also, lead has been found in the wrappers of some imported candies. The ink of these plastic or paper wrappers may contain lead that leaches into the candy.

More information and advisories on lead in candy can be obtained from the FDA at www.fda.gov or 1-888-463-6332.

MedChi, The Maryland State Medical Society

Christy Woods, MedChi

MedChi works with the Center for Maternal and Child Health, Department of Health and Mental Hygiene to provide technical assistance to local FIMR programs. Technical assistance services include:

- ❖ Developing data tools
- ❖ Developing Action Plans
- ❖ Maintaining Resource Center
- ❖ Conducting trainings for FIMR staff
- ❖ Highlighting local FIMR activities and best practices
- ❖ Presenting to FIMR Community Action or Case Review Team
- ❖ Coordinating and facilitating the Maryland FIMR Advisory Group meetings

MedChi staff are available upon request to present at local FIMR Meetings on various topics related to conducting case reviews and implementing community action. For more information or to request assistance, please call 410-539-0872 extension 357 or e-mail cwoods@medchi.org for Christy Woods, or extension 322 or mabraham@medchi.org for Meena Abraham.

SAVE-THE- DATE: Friday, April 15, 2005

MedChi will conduct a FIMR Introduction/Refresher Training and a Peer-to-Peer Discussion on Effective Maternal Interviewing.

MedChi
The Maryland State Medical Society

U.S. Health Improvements Slowing—IMR & Obesity Partly Responsible

A report released by United Health Foundation, the American Public Health Association and Partnership for Prevention, titled "America's Health: State Health Rankings—2004 Edition," is a state-by-state analysis showing that the nation's progress in improving overall health is "slowing dramatically," and the increases in obesity and infant mortality rates are causes for concern. From 1990 to 2004, the infant mortality rate decreased 31 percent. However, last year, the rate increased for the first time in 40 years, from 6.9 to seven deaths in the first year of life for every 1,000 live births.

In addition, other maternal risk factors, such as age, obesity, smoking, infection and stress, are associated with increased infant mortality. More than 75 infants die in the United States each day, according to CDC data and the United States now ranks 28th in the world in infant mortality.



New Maternal and Child Health Training Resource

The Maternal and Child Health (MCH) Training Program of the Maternal and Child Health Bureau has launched a new Web site to support the education and training of those working in the MCH professions. The MCH Training Program supports trainees, faculty, continuing education, and technical assistance. The new Web site provides information on new funding opportunities, writing a grant proposal, currently funded projects, and reporting requirements. The Web site also includes an events calendar, conference archives, a glossary, a PDF document library, and other resources relevant to the program. The Web site is available at: www.mchb.hrsa.gov/training



Planned Parenthood of Metropolitan Washington's Hispanic Health Initiative

Soraya Galeas, Hispanic Initiative Coordinator

Planned Parenthood of Metropolitan Washington (PPMW) is pleased to announce the return of *Abriendo Caminos*, a Health Initiative for the Hispanic Community. PPMW's Hispanic Initiative Coordinator Soraya Galeas will conduct bilingual single and multi session workshops for youth and adults in the District, Maryland and Virginia. A sample of a workshop topics offer include:

- ◆ Parenting Skills
- ◆ Parent / Child Communication
- ◆ Puberty Changes
- ◆ Abstinence
- ◆ Sexual and Reproductive Anatomy
- ◆ Family Planning

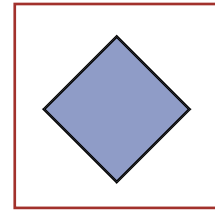
Organizations select from these topics or request other topics based on the needs, age and risk level of their clients.

Teen Clinic

As part of the Hispanic Initiative, PPMW's Gaithersburg Health Center is offering FREE, confidential and bilingual clinical and education services to teen's on designated days to encourage greater access to reproductive health care.

PPMW's mission is to provide high quality, affordable reproductive health care; promote education programs that empower all individuals to make informed and responsible reproductive choices; and to protect the right to make those choices through research, education, advocacy and service.

For more information, please contact Soraya Galeas at 202-497-4173.



Youth "Too Embarrassed" To Buy Condoms

Many young people are hesitant to buy condoms to protect against sexually transmitted diseases because they say they are "too embarrassed" by the experience, according to a study published in the *Social Science Journal*. Kimberly Brackett of Auburn University asked about 250 University of Florida students to buy condoms and then write a paper about the experience. If a student did not purchase condoms, they were asked to write about why they chose not to purchase them.

According to the study, 25 students said they were unable to buy condoms, including one woman who cited having "too much embarrassment." Many of the 78 men and 176 women who did buy condoms said they were buying condoms for the first time, and many students said they were embarrassed during the experience, although men reported less embarrassment. Some men and women sought out a clerk of the same sex, tried to conceal the condom box or bought other items to distract attention.

In addition, both men and women looked out for other customers while buying the condoms, although more women than men waited for other customers to leave, and more women brought friends along as "allies" during the purchase, according to the study. The study said that some women "told the clerk at the time of purchase that it was for an assignment so the clerk wouldn't get the 'wrong idea.'" Students reporting the least embarrassment said that buying condoms was the "responsible thing to do." Brackett said that more students might buy condoms if it is "stressed" as responsible behavior.

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Hispanic Teen Pregnancy and Birth Rates: Looking Behind the Numbers

By Suzanne Ryan, Ph.D., Kerry Franzetta, and Jennifer Manlove, Ph.D.

While teen pregnancy and birth rates for all U.S. teens have declined dramatically in recent years, this decline has been slower for Hispanic teens. In fact, these rates remain higher for Hispanics than for the population as a whole.

In light of these trends, Child Trends' newest research brief—Hispanic Teen Pregnancy and Birth Rates: Looking Behind the Numbers—brings together new analyses and recent statistics from several sources to examine the sexual, contraceptive, and relationship behaviors of Hispanic teens. "This kind of information can be helpful to providers of teen pregnancy prevention programs as they seek to target these programs more effectively to Hispanic teens," says Suzanne Ryan, Ph.D., lead author of the brief.

Teen pregnancy and birth rates within the Hispanic population, although they have dropped, remain a cause for concern, given research showing the negative consequences early pregnancy and childbearing can have for both teen mothers and their children, adds Ryan. For example, teen mothers are more likely to drop out of high school, to struggle economically, and to spend their adult years as single parents than those who delay childbearing until they are older. And, compared with the children of older mothers, the children of teen mothers are more likely to face a host of difficulties from being of low-birthweight as a baby to getting into trouble as a teenager.

Pregnancies and births

The Hispanic teen pregnancy rate in 2000 (the latest year for which data

are available) was 137.9 pregnancies per 1,000 teen females aged 15 to 19, compared with 83.6 for the overall U.S. teen population. The Hispanic teen birth rate in 2003 was 82.2 births per 1,000 teen females aged 15 to 19, compared with 41.7 for the overall U.S. teen population.

Between 1990 and 2000, the pregnancy rate declined by 29 percent for all teens, but only declined by 15 percent for Hispanic teens. The birth rate for all teens has declined by 33 percent since 1991 (the most recent peak in the teen birth rate), but the birth rate for Hispanic teens has declined by only 21 percent.

Before their twentieth birthday, an estimated 24 percent of Hispanic young women will have given birth to at least one child, compared with 13 percent of U.S. young women overall.

In 2000, less than one-quarter (22 percent) of Hispanic teen pregnancies ended in abortion, compared with almost 3 in 10 (29 percent) pregnancies among all teens. The combination of higher pregnancy rates and a lower percentage of abortions accounts for the higher birth rates among Hispanic teens.

In 2002, only 46 percent of never-married Hispanic teen females said they would be very upset if they got pregnant, compared with 60 percent of all never-married teen females who held this view.

Sex, relationships, and contraception

In 2002, 47 percent of never-married Hispanic teens reported that they were sexually experienced (had ever had sex), but only 34 percent said they were sexually active (had sex at least once in the previous three months). The percentages for all U.S. teens were comparable: 46 percent were sexually experienced and 33 percent were sexually active.

Hispanic teens in grade 7 through 12 reported that they talked about contraception with their partners before having sex in less than one-half (46 percent) of their relationships,

compared with more than one-half (52 percent) of the time across all sexual relationships among U.S. teens.

In 1995-1996, Hispanic teens in grades seven through twelve reported they used no contraceptive method at all in 31 percent of their sexual relationships, while among teens of all racial and ethnic backgrounds, contraception was not used at all in 24 percent of sexual relationships. More than one-half of Hispanic teens (55 percent) and all teens (58 percent) used contraception consistently, that is, they relied on some form of contraception every time they had sex and within each of their sexual relationships.

For Hispanic high school teens, condom use during the most recent sexual experience has increased significantly in the past decade, from 37 percent in 1991 to 57 percent in 2003. However, condom use remained somewhat less prevalent among Hispanic high school teens than among high school teens overall (57 percent versus 63 percent, respectively).

Hispanic teen females are substantially less likely than teen females in the overall population to use birth control pills. In 2003, only 12 percent of Hispanic high school females reported using birth control pills during their most recent sexual experience, compared with 21 percent of high school females overall.

The number one reason Hispanic teens who had never had sex give for remaining virgins is that they did not want to get themselves or their partners pregnant. In 2002, this was true for 32 percent of virgin Hispanic teens surveyed, compared with 22 percent for all teens surveyed.

The brief also suggests approaches that may be effective in reducing the relatively high risks of teen pregnancy and childbearing among Hispanics, the fastest-growing population in the U.S.

To access the full study, go to: www.childtrends.org/Files/HispanicRB.pdf.

Preconception Care—A New Paradigm in Perinatal Care

Tina Khoie, MD, MPH, Preventive Medicine Resident, University of Maryland

Unintended pregnancies, defined as either unwanted or mistimed, account for approximately half of all pregnancies nationally, and 42 percent of pregnancies in Maryland. Women who carry unintended pregnancies to term are more likely to receive delayed prenatal care, have low-birth-weight infants and have unhealthy behaviors, such as alcohol and tobacco use during pregnancy. Two of the goals of Healthy People 2010 are: (1) to increase the proportion of intended pregnancies among women between 14-44 years of age from 51 percent to 70 percent; and (2) to increase the percentage of women using contraception among those at risk for unintended pregnancies. Maryland's most recent data show that 55 percent of women with unintended pregnancies report no use of contraception at the time of pregnancy.

The current approach to perinatal care is disconnected and incomplete. The focus is primarily on prenatal care that begins during the first trimester, and preconception care prior to pregnancy is not emphasized. Many women covered by Medicaid become eligible only after becoming pregnant; thus, they lack any sort of comprehensive medical care coverage prior to pregnancy. Maryland data from 2001 revealed that 78 percent of pregnant women began prenatal care during the first trimester. Pregnancy related health complications reported by mothers in Maryland included preterm labor (27 percent), pre-eclampsia (17 percent), diabetes (8 percent) and premature rupture of the membranes (five percent).

Perinatal problems constitute the current leading cause of death amongst infants and toddlers three years and younger, accounting for 44 percent of deaths. Despite the increase in the percentage of women who begin prenatal care during their first trimester of pregnancy from 76 percent in 1990 to 84 percent in 2002, perinatal health indicators have continued to increase. Preterm births have increased steadily from 9 percent in 1981 to 11 percent in 1990 and to 12 percent in 2002. The percentage of low birth weight (LBW) babies has increased from seven percent in 1984 to 8 percent in 2002. Although national infant mortality rates (IMR) have declined from nine percent in 1990 to seven percent in 2002, they have remained steady at about seven percent since 2000. The decline in the IMR during the 1980s is attributed to improvements in neonatal and obstetric care, which resulted in a decline in birth-weight-specific IMRs, and not in a reduction of premature and LBW deliveries.

A greater emphasis on preconception care is warranted, because about half of all pregnancies are unintended. This approach would address health prior to childbearing and during interconception periods, rather than beginning during the first trimester of pregnancy. The latter approach, for example, potentially misses the opportunity to help women reduce unhealthy behaviors like drinking alcohol and smoking while a fetus is in the early and critical stages of development. Maternal risk factors should all be addressed early on in a woman's reproductive lifecycle in order to make a positive impact on perinatal morbidity and mortality. Two CDC survey studies showed that providers are not aware that each encounter with a woman of reproductive age represents an opportunity to promote preconception health.

The goal of preconception care is to identify and address risk factors of maternal complications prior to pregnancy in an effort to improve perinatal morbidity and mortality. Prenatal care that begins sometime between the fourth and eighth week of pregnancy, as is common in unintended pregnancies, is prenatal care that begins too late. Primary care providers should take every opportunity available to counsel women at reproductive age regarding unintended pregnancy and healthy lifestyles and behaviors that impact pregnancy outcomes, regardless of a woman's intention of becoming pregnant. Such a comprehensive approach to reproductive health will help ensure that we start off right with healthy mothers and, consequently, a better chance at healthy babies.



Pregnancy Outcomes for Type 2 Diabetics Increasingly Poor

Women who have type 2 diabetes are more likely to have poor pregnancy outcomes than nondiabetic women or women with type 1 diabetes, according to a study published in the February issue of *Diabetes Care*. In addition, pregnancy outcomes for women with type 2 diabetes seem to have worsened over time.

Dr. Tine Clausen and colleagues in the department of obstetrics at Copenhagen University Hospital in Denmark studied the medical records of 61 women with type 2 diabetes who gave birth at a Copenhagen hospital between 1996 and 2001. They compared the records to those of women with type 1 diabetes and nondiabetics who gave birth during the same period, as well as the records of women with type 2 diabetes who gave birth between 1980 and 1992, Reuters Health reports. According to the study, women with type 2 diabetes were four times as likely as type 1 diabetics and nine times as likely as nondiabetics to give birth to an infant who died during or shortly after delivery.

In addition, there were four fetal or newborn deaths and four "major" birth defects among the 61 type 2 diabetics between 1996 and 2001, but no deaths or defects were recorded among type 2 diabetics who gave birth from 1980 to 1992, according to the study. The rate of preterm deliveries was twice as high in type 2 diabetics in the 1996 to 2001 group as in the 1980 to 1992 group. The women in the 1996 to 2001 group also were heavier and older than the women in the 1980 to 1992 group. "It is possible that the early onset of diabetes may be associated with increasingly poor pregnancy outcomes," Clausen said in a statement, adding, "Certainly, it's time to pay closer attention to the health care being delivered to women who develop type 2 diabetes before or during their childbearing years."

Reprinted with permission from the Kaiser Daily Health Report

Somerset County Health Department “Cool Babies” Prevention Program Established

Charity Holley, MA, Director of Health Promotion and Disease Prevention, Somerset County Health Department

Although child deaths and death rates are declining in Maryland, there is still ample room for improvement. The most common causes of death in children and adolescents are frequently related to preventable factors. In many cases, reviewing the circumstances surrounding the death can provide important information which can direct prevention initiatives. In December 2004 the Somerset County Child Fatality Review Team (CFRT) reviewed and identified problems/needs related to infant and child fatality. It was determined that there seemed to be a problem with bedding related issues. Some children had no appropriate bedding, some were bed sharing, and others had improper bedding placed with the child.

The CFRT made the recommendation to develop culturally appropriate, low-literacy, educational brochures, posters, and billboards to address the improper bedding issue. Following the recent Consumer Health Profiles report from the National Cancer Institute, the health department chose to follow the chronic disease prevention health delivery message model for Somerset County. The report noted that Somerset County residents tend to receive health messages from outdoor advertising, written in direct mail, or on local television. The educational campaign has enabled the message “Cool Babies Sleep Safest on their Backs” to reach families most in need. Educational packets were created both in English and Spanish, and consisted of the national Back to Sleep campaign information, Tummy Time light switch plates, Safe Sleep onesies, and other minor incentives. The packets were also distributed through the Healthy Start and Migrant programs at the Health Department.

In addition to an educational need being identified, the CFRT also identified the lack of appropriate or no bedding. Therefore, the Pack-N-Play component was adopted to assist needy families. The Pack-N-Plays are given free of charge to those meeting an income qualification, and the caregiver must receive a fifteen minute demonstration on proper bedding along with smoking cessation if necessary. Information on the Pack-N-Play component has been distributed to the local hospital, federally qualified health center (FQHC), daycare providers, OB/GYN's, Department of Social Services, Maryland State Police, Catholic Charities, and Child Protective Services.

Reducing the risk of SIDS and SUDI deaths in our community has become a recent outreach initiative. It is our hopes that through the “Cool Babies” campaign to prevent unnecessary child deaths in the county.

For more information, please contact Charity Holley, Director of Health Promotion and Disease Prevention at the Somerset County Health Department at 443-523-1760.



Infant Oral Health Guide

Bright Futures in Practice: Oral HealthPocket Guide is a resource to assist health professionals in providing oral health care for infants, children, adolescents, and pregnant and postpartum women. The pocket guide was developed by the National Maternal and Child Oral Health Resource Center working in collaboration with the Bright Futures Education Center at the American Academy of Pediatrics, with support from the Maternal and Child Health Bureau.

The pocket guide offers health professionals an overview of preventive oral health supervision for five developmental periods—pregnancy and postpartum, infancy, early childhood, middle childhood, and adolescence. It is designed to be a useful tool for a wide array of health professionals including dentists, dental hygienists, physicians, physician assistants, nurses, dietitians, and others. The pocket guide is available from the Bright Futures Oral Health Toolbox at: www.mchoralhealth.org/Toolbox/professionals.html.



CDC Launches New Webpage on Perinatal Hepatitis B

CDC's National Immunization Program (NIP) has recently added a web page of perinatal hepatitis B information to its Web site. The new section features pertinent brochures, flyers, slide sets, and Web sites for parents, healthcare professionals, and state hepatitis B coordinators.

The new web page also includes a link to 2003 National Immunization Survey (NIS) data, which includes the 2003 birth dose data.

Available at www.cdc.gov/nip/diseases/hepB/pubs_other.htm

Breastfeeding Promotion in Maryland

Hanan Aboumatar, MD, MPH; Lily Fountain, MS, CNM, RN; Maryland Breastfeeding Task Force

The Maryland Breastfeeding Promotion Task Force was convened in the fall of year 2002. The Task Force serves as a forum for identifying strategies and coordinating efforts to promote and support breastfeeding in Maryland. The Maryland Breastfeeding Task Force holds quarterly meetings. Members include physicians, lactation consultants, nurses, midwives, and other breastfeeding experts from the state of Maryland. The Task Force has identified four general areas on which to focus its efforts. These areas are:

- ▲ Healthcare professional education about breastfeeding
- ▲ Breastfeeding promotion in the community to establish breastfeeding as the public norm.
- ▲ Breastfeeding support in the workplace.
- ▲ Breastfeeding support through health care insurance plans.

The Task Force has assembled a professional speakers' bureau that attends to the educational needs of the medical community in the area of breastfeeding. Several presentations at medical grand rounds and other professional conferences have been held. To request a presentation at your facility please contact Dr. Dana Silver at dsilver@lifebridgehealth.org.

A new 'breastfeeding Web site' has been launched on the Maternal and Child Health Center Web site of the Maryland Department of Health and Mental Hygiene. The Web site includes sections on breastfeeding statistics, breastfeeding and Maryland law, and breastfeeding support in the workplace and childcare facilities. In addition, special sections contain information and resources for parents and families, health professionals, health organizations, and educators. The 'Maryland Breastfeeding Resource Handbook' developed by the Johns Hopkins School of Nursing is also available on this Web site in the resource section. The Web site address is: www.fha.state.md.us/mch/breastfeeding

The efforts of the Maryland Breastfeeding Promotion Task Force complement the ongoing national breastfeeding awareness campaign. This campaign is the result of a collaboration effort between the U.S. Department of Health and Human Services and the Ad Council. The campaign stresses the 'Babies Were Born to Be Breastfed' message and calls for exclusive breastfeeding for six months. Campaign materials include TV and radio ads, along with posters for billboards. All campaign materials can be accessed at: www.adcouncil.org/campaigns/breastfeeding/. The Ad Council, in regards to the ongoing campaign, has contacted all major media markets, including the ones in our region. Breastfeeding advocates are encouraged to contact their local media and health departments, inquire about the campaign and ask that its materials be disseminated in their local community.

For additional information about the Maryland Breastfeeding Task Force and its activities please contact:

Mary D. Johnson, Maryland Breastfeeding Task Force, Department of Health and Mental Hygiene, Center for Maternal and Child Health
Phone: 410-767-5581
Fax: 410-333-5233
MDJohnson@dnhmh.state.md.us



American Academy of Pediatrics Revises Policy Statement on Breastfeeding

Breastmilk and the Use of Human Milk cites substantial new research on the importance of breastfeeding and sets forth principles to guide pediatricians and other health professionals in assisting women and children in the initiation and maintenance of breastfeeding. The policy statement replaces the American Academy of Pediatrics' 1997 policy statement on breastfeeding, and emphasizes the central role of the pediatrician in coordinating breastfeeding management and providing a medical home for the child.

American Academy of Pediatrics, Section on Breastfeeding. 2005. Breastfeeding and the Use of Human Milk. Policy Statement. Pediatrics 115(2):496-506. Abstract available at:

<http://pediatrics.aappublications.org/cgi/content/abstract/115/2/496>.



FREE POSTERS!

From the National Breastfeeding Awareness Campaign

The posters come as a set of five with the following messages:

- 1) Babies Were Born to Be Breastfed (Black with white lettering.)
- 2) Breastfeed for 6 Months. You may help reduce your child's risk for childhood obesity. (Pictured—two scoops of ice cream with cherries on top.)
- 3) Breastfeed for 6 Months. Help reduce your child's risk for respiratory illnesses. (Picture—two dandelions gone to seed.)
- 4) Breastfeed for 6 Months. Help reduce your child's risk for ear infections. (Picture—two otoscopes.)
- 5) Spanish version—Breastfeed for 6 Months. Help reduce your child's risk for ear infections. (Picture—two otoscopes.)

Other free publications include: An Easy Guide to Breastfeeding, available in English, Chinese, Spanish, and for American Indian and Alaska Native Families, and for African American Women.

Call the Office on Womens Health, National Womens Health Information Center at 800-994-9662.

Guidelines for Care of Pregnant Women with Asthma

The National Asthma Education and Prevention Program, a part of the National Heart, Lung and Blood Institute has released new guidelines for care of pregnant women with asthma. Asthma can cause serious medical problems for pregnant women and their fetuses, and physicians should closely manage their pregnant patients who have asthma. Developed by a NAEPP panel chaired by Dr. William Busse, professor of medicine at the University of Wisconsin Medical School, the guidelines warn that the fetuses of pregnant women who have trouble breathing because of asthma are at risk of receiving inadequate oxygen. Although some asthma drugs might negatively affect a woman's fetus, the drugs pose less of a risk to the fetus than lack of oxygen from the woman's untreated asthma. "The evidence is reassuring, and suggests that it is safer to take medications than to have asthma exacerbations," NHLBI Director Dr. Barbara Alving stated, adding, "The guidelines should be a useful tool for physicians to develop optimal asthma management plans for pregnant women." Asthma—which affects more than 20 million Americans and up to eight percent of pregnant women—is associated with a higher risk of infant death, preeclampsia, premature birth and low birthweight. According to the guidelines, about one-third of women with asthma experienced worsening symptoms during pregnancy, while about one-quarter see an improvement.

The guidelines recommend a "stepwise" approach to treating asthma, meaning medication is increased if needed and decreased if possible, depending on the severity of the asthma. The guidelines also emphasize that women should seek to reduce exposure to asthma triggers since a pregnant woman can reduce how much medication is needed by identifying and avoiding the factors that make her asthma worse, such as tobacco smoke or dust mites. Women with related conditions that might worsen asthma—including allergic rhinitis, sinusitis and gastroesophageal reflux—should seek treatment because the conditions might become more troublesome during pregnancy.

OB/GYNs should "be part of the patient's asthma management team" in order to help "lower the risk of complications from asthma" for both pregnant women and their infants, stated Dr. Mitchell Dombrowski, chief of obstetrics and gynecology at St. John Hospital in Detroit and a NAEPP panel member. In the opinion of Dr. William Busse, there are many ways to help pregnant women control their asthma, and it is imperative that providers and their patients work together to do so.

The guidelines provided these additional recommendations:

- ❖ Albuterol—a short-acting inhaled drug—can be used as a quick-relief medication for asthma symptoms, and pregnant women with asthma should have this medication available at all times.
- ❖ Inhaled corticosteroids are the preferred medication to help control inflammation for women with persistent asthma.
- ❖ Women with persistent asthma whose symptoms are not controlled on low doses of inhaled corticosteroids can either increase the dosage or add a long-acting beta agonist as another medication.
- ❖ Oral corticosteroids might be needed to treat severe asthma, although conflicting data exist about the safety of this medication during pregnancy.

Journal of Allergy and Clinical Immunology, January 2005



Surgeon General Advises No Alcohol Before/During Pregnancy

Surgeon General Richard Carmona has advised pregnant women and women who might become pregnant to abstain from alcohol consumption to eliminate the chance of giving birth to an infant with any of the fetal alcohol spectrum disorders. Fetal alcohol spectrum disorders include any birth defects caused by prenatal alcohol exposure, from a slight learning disability or physical abnormality to fetal-alcohol syndrome, which is characterized by severe learning disabilities, growth deficiencies, abnormal facial features and central nervous system disorders.

Carmona's advisory updates a 1981 surgeon general's advisory suggesting that women "limit" the amount of alcohol they drink while pregnant. Carmona's announcement came in advance of his participation in BirthDay Live!, a 10-hour live television broadcast on the Discovery Health Channel showing women giving birth in three locations nationwide. Carmona's announcement and participation in the event are part of his 2005 agenda, titled "The Year of the Healthy Child." As part of his 2005 agenda, Carmona will focus on ways women can keep themselves healthy before and during pregnancy by abstaining from alcohol and tobacco use, exercising regularly, taking folic acid and other vitamin supplements and having a healthy diet. Carmona this year also plans to focus on prenatal care, pregnancy and early childhood development.

Office of the Surgeon General release, 2/21

Save a Baby with Just a Few Steps

WalkAmerica 2005

By: Angela Bzdek

The March of Dimes is a nonprofit organization whose mission is to improve the health of babies by preventing birth defects and infant mortality. This mission is carried out through research, community services, education, and advocacy. With the help of staff and volunteers working together, the March of Dimes is trying to give all babies a fighting chance against threats to their health, such as prematurity, birth defects and low birthweight. Every year, the March of Dimes holds WalkAmerica, a 10-kilometer or 6-mile walk. It is the March of Dimes largest fund-raiser, involving almost 1,200 communities throughout the United States. Since its beginning in 1970, WalkAmerica has raised more than \$1.5 billion nationally. Funds raised from this event help save babies lives. WalkAmerica is the nations first and best-loved walking event, held annually during the months of April and May. In Maryland, WalkAmerica will take place at the following locations on the dates listed in the sidebar.

Now in its 35th year, WalkAmerica is expected to draw more than 7 million men, women and children who will participate as sponsors, volunteers and walkers nationwide, and 25,000 in Maryland. To register for WalkAmerica, call 1-800-525-WALK (9255), or visit our Web site at www.WalkAmerica.org and click on register online now. Follow these next three steps and you are ready to walk.

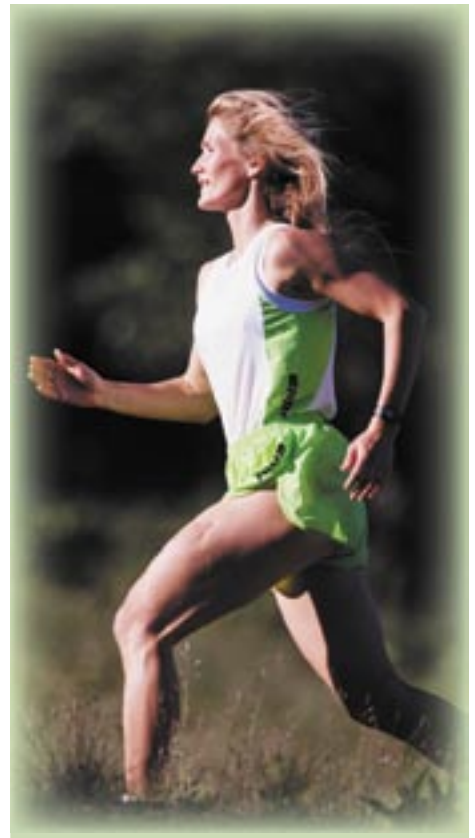
- * Decide if you will be walking with a team or as an individual; check the one that applies to you and click submit.
- * Next, select your walk site either by entering your zip code or clicking on your state. Scroll down until you find a walk site that is closest to where you live and click on select this walk.
- * Lastly, fill out all of the required information on your registration form and when finished, you are ready to raise money to help save babies lives.

The March of Dimes spends 75 percent of the money raised in WalkAmerica on:

- * Research into why premature birth happens and how it can be prevented
- * Education to help women have healthy pregnancies and recognize the signs of preterm labor
- * Assistance for health care providers in better identifying women at risk for premature birth Information and help for families of babies in neonatal intensive care units (NICUs)
- * Help for pregnant women with questions and concerns about pregnancy through the Pregnancy & Newborn Health Education Center at marchofdimes.com or askus@marchofdimes.com.

In the United States, one out of eight babies is born prematurely. That adds up to more than 470,000 babies every year, and the number is on the rise. Maryland ranks 44th in the nation, with 50th being the worst, for preterm birth rate and 38th in the nation for infant mortality rate. The March of Dimes lifesaving research is seeking causes of and treatments for prematurity and birth defects. Our advocacy efforts in state and federal government are making it possible for more parents to get health coverage and care for their babies and children. With your support, we will reach the day when every baby can be born full-term and healthy. So what are you waiting for? Put on your walking shoes and join us for a day of fun and help Maryland's babies get a healthy start in life. See you at the 2005 WalkAmerica!

For more information please contact: Elli K. Straus
Phone: 410-752-8178
E-mail: estraus@marchofdimes.com



April 23

Allegany County WalkAmerica

Cumberland, Downtown to C and O Canal
Towpath Walk begins at 8:00 a.m.

Worcester County WalkAmerica

Assateague State Park, Route 611 at
Ocean Walk begins at 10:00 a.m.

April 24

Charles County WalkAmerica

LaPlata, County Government Building

Registration begins at 8:00 a.m.

Walk begins at 9:00 a.m.

Frederick County WalkAmerica

Baker Park Bandshell, Bentz and Patrick
Streets Walk begins at 1:30 p.m.

Wicomico County WalkAmerica

Salisbury Moose Lodge, Snow Hill Road
Walk begins at 10:00 a.m.

Harford County WalkAmerica

Forest Hill, Route 23 between Route 24
and Connowingo Road. Walk begins at
7:00 a.m.

Anne Arundel County WalkAmerica

Navy/ Marine Corps Stadium (Annapolis).
Registration begins at 8:00 a.m. Walk
begins at 9:00 a.m.

April 30

Washington County WalkAmerica
Long Meadow Shopping Center Walk
begins at 9:00 a.m.

May 1

Baltimore City WalkAmerica
Phillips Food World Headquarters, East
Fort Avenue Registration begins at 8:00
a.m. Walk begins at 9:00 a.m.

Baltimore County WalkAmerica
Towson University. Registration begins at
8:00 a.m. Walk begins at 9:00 a.m.

Prince Georges County WalkAmerica
Largo/ Boulevard at the Capital Center.
Registration begins at 8:00 a.m. Walk
begins at 10:00 a.m.

Calvert County WalkAmerica
Solomons Island Gazebo Waterfront
Registration begins at 8:00 a.m. Walk
begins at 9:00 a.m.

**Columbia- Howard County
WalkAmerica**
Howard County Community College,
Grand Prix Field Walk begins at 9:00
a.m.

May 7

Cecil County WalkAmerica
North East Town Park. Registration begins
at 7:15 a.m. Walk begins at 8:00 a.m.
15th- MidShore WalkAmerica
Federalsburg Marina and Park, South
Main Street and Bypass Route 318 Walk
begins at 1:00 p.m.

May 15

Montgomery County WalkAmerica
Rockville, King Farm. Registration begins
at 9:00a.m. Walk begins at 10:00 a.m.

September 10

Garrett County WalkAmerica
Deep Creek Lake State Park. Registration
begins at 8:00 a.m. Walk begins at 9:00
a.m.

Effect of Maternal Weight on Labor Progression

In this study, overweight and obese women had a significantly slower labor from four to 10 cm, compared with that of normal-weight women. The authors note that prevalence of overweight and obesity is increasing among women of childbearing age, yet few studies have explored in depth the effect of maternal overweight and obesity on labor progression. The study examines the effect of maternal overweight and obesity on the pattern of labor progression after adjusting for potential confounders in current obstetric practice.

Women in this study were participants in the Pregnancy, Infection, and Nutrition Study (PINS), an ongoing, prospective cohort study to examine the determinants of preterm birth. Between August 1995 and March 2002, PINS recruited 3,625 women. Maternal prepregnancy body mass index (BMI), the exposure of interest, was computed based on the following Institute of Medicine weight-for-height categories: normal weight (BMI 19.8–26.0 kg/m²), overweight (BMI 26.1–29.0 kg/m²), and obese (BMI greater than 29.0 kg/m²). Women were eligible for this analysis if they met the following additional inclusion criteria: nulliparous, a maternal prepregnancy BMI of 19.8 kg/m² or higher, and a term delivery. The final study sample included 612 women (297 normal weight, 115 overweight, and 200 obese). The median duration of labor by each centimeter of cervical dilation was computed for each BMI category and used as a measurement of labor progression.

The authors found that:

- Compared with normal-weight women, both overweight and obese women were admitted earlier (based on cervical dilation assessment) to labor and delivery, more frequently reported no or irregular uterine contractions, more frequently had their labor induced, and received oxytocin more often.
- Primary emergent cesarean delivery rates were higher for overweight and obese women compared with normal-weight women. The majority of these deliveries were performed during the first stage of labor because of an indication of dystocia and fetal distress.
- Overweight and obese women had a significantly longer median duration of labor from four to 10 cm compared with normal-weight women (7.5, 7.9, and 6.2 hours, respectively), after adjusting for maternal height, net weight gain, labor induction, membrane rupture, the timing and use of epidural analgesia, oxytocin use, and fetal size.
- Compared with normal-weight women, the general trend of a slower labor from four to six cm persisted in overweight women, and the trend of a slower labor before seven cm persisted in obese women.

Given that nearly one half of women of childbearing age are either overweight or obese, it is critical to consider differences in labor progression by maternal prepregnancy BMI before additional interventions are performed, conclude the authors.

Vahratian A, Zhang J, Troendle JF, et al. 2004. Maternal prepregnancy overweight and obesity and the pattern of labor progression in term nulliparous women. *Obstetrics and Gynecology* 104(5, Part 1):943–951.



Calendar Events

April

Fourth Annual Perinatal Infections Grand Rounds Lecture Series.

"Antibiotics in Prematurity: Who, What, When, How? Friday, April 8 7:30–8:30 a.m. A presentation for the Department of Obstetrics at GBMC in GBMC's Physician Pavillion East, Conference Room C. The lecture will be presented by Lindsay S. Alger, MD, a professor in the Department of Obstetrics, Gynecology and Reproductive Sciences at the University of Maryland, School of Medicine. Dr. Alger is also Medical Director of Labor and Delivery, Associate Director of the Division of Maternal-Fetal Medicine, and Director of Undergraduate Medical Education. Her major fields of research include premature labor, sexually transmitted diseases in pregnancy, and HIV in pregnancy. Dr. Alger was named one of Baltimores Best Doctors in 2002 by Baltimore Magazine.

Please call/e-mail Elisabeth Liebow, Coordinator, Perinatal Infections Outreach Program Baltimore County Department of Health if you plan to attend and for directions.

Phone: 410-377-5397,

E-mail: eliebow@co.ba.md.us

A Practical Update on Sexually Transmitted Infections: Advances in Diagnosis and Treatment.

Jointly sponsored by Boston University of Medicine and OB.Gyn.News & Family Practice News. April 9-10 in Washington, D.C. Two Hopkins expert will be presenting/moderating at the conference: Dr. Anne Rompalo (Associate Professor, Infectious Diseases Division) and Dr. Jonathon Zenilman (Professor, Infectious Diseases Division). To view the conference brochure and register, go to: www.bu.edu/cme and click on the appropriate conference.

Effective Maternal Interviewing

MedChi will conduct a FIMR Introduction/ Refresher Training and a Peer-to-Peer Discussion on Friday, April 15. For more information or to request assistance, please call 410-539-0872 extension 357 or e-mail cwoods@medchi.org for Christy Woods, or extension 322 or mabraham@medchi.org for Meena Abraham.

Montgomery County ICAP Professional Summit on Teen Pregnancy & Teen Parent Conference

April 20, University of Maryland, Shady Grove Center

"Believe in Yourself, Believe in Your Future." Workshops on parenting, labor and delivery, child's rights, relationships, sex and STDs, dads and babies, sessions in Spanish, graduation and GED, recognition and resource fair, food and transportation. Free pregnant and parenting teen Moms and Dads sessions 8:30 am-12:30 pm. Professional Summit on Teen Pregnancy immediately following from 12:30 p.m.—3:00 p.m. Parents, educators, service providers, community partners, and professionals are urged to attend.

For registration and information contact: Jane Larsen 240-777-1570, e-mail: jane.larsen@montgomerycountymd.gov

Twenty-third Annual Reproductive Health Update

Friday, April 29, 8:45 a.m.—3:30 p.m. Registration begins at 8:00 a.m.

Ten Oaks Ballroom, Clarksville (Howard County), Maryland. Registration fee \$30, includes continental breakfast, lunch and conference materials.

Now in its 23rd year, the Reproductive Health Update provides a comprehensive review of selected family planning knowledge, skills and current issues for reproductive health care providers in Maryland and from around the region who offer low-cost, high-quality reproductive health services to women and men in need. Topics are identified to meet continuing educational needs of reproductive health professionals regardless of their discipline or practice setting.

Nursing contact hours and social work credit hours are available. American College of Nurse Midwives specialty credit has been applied for.

For more information contact Helene O'Keefe, phone 410-767-6723, e-mail okeefeh@dhhm.state.md.us

May

21st Annual State Conference on Teen Pregnancy & Parenting.

Heading In the Right Direction ~ Youth follow our lead! Sponsored by the interagency efforts of the Governor's Office for Children, Youth, and Families, Department of Health and Mental Hygiene, Department of Human Resources, and Maryland State Department of Education. University of Maryland Baltimore County.

May 20—Conference for Professionals and Concerned Adults

May 21—Winning Choices Plus for Youth and Parents

For more information, contact: Governor's Council on Adolescent Pregnancy
Phone: 410-767-4160

Child Fatalities Workshop: A Series for First Responders

Sponsored by Cecil Partnerships for Childen, Youth and Families. Perry Point VA Center Conference Center, Building 314. March 14, April 21, May 24, This free series is for law enforcement, emergency medical technicians, social workers, nurses, counselors, bereavement specialists and school personnel.

For more information, call 410-620-3802 or e-mail vgrahm@dol.net

June

2005 National HIV Prevention Conference

June 12-15, Hyatt Regency Atlanta Hotel.

The Centers for Disease Control and Prevention (CDC) joins other governmental and non-governmental prevention partners to announce the fourth conference highlighting HIV prevention in the United States. For information:

www.2005hivprevconf.org/